Community Report

THIRD VISIT
2000-2001

LITTLE ROCK · ARK.

Spring 2001

In December 2000, a team of researchers visited Little Rock, Ark., to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 50 leaders in the health care market. Little Rock is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first two site visits to Little Rock, in 1996 and 1998, provided baseline and initial trend information against which changes are tracked. The Little Rock market includes Faulkner, Lonoke, Pulaski and Saline counties.

Hopes Dim for More Competition

In 1998, Little Rock health plans and providers were optimistic that partnerships with national firms would bolster their ability to challenge the powerful positions of the market's dominant health plan and provider system, Arkansas Blue Cross Blue Shield (ABCBS) and Baptist Health System. Two years later, optimism has faded as many of these would-be competitors face mounting financial and operational problems, eroding their competitive potential. The departure of various health insurers since 1998 has further constrained competition. As health care costs increase and premiums rise, many observers fear that health insurance coverage will become increasingly prohibitive for some consumers, leading to more uninsurance in the state, where nearly one in seven persons currently goes without coverage.

Other important developments in Little Rock since 1998 include:

- Expansion of specialty services and capacity threatens to erode local hospitals' revenue base.
- Premiums have escalated, as cost controls remain elusive.
- Financial problems have plagued the area's predominant safety net provider.

Little Rock Demographics

Little Rock	*Metropolitan areas above 200,000 population*
Population, July 1, 1999 [1]	
579,795	
Population Change, 1990-1999 [2]	
8.4%	*8.6%*
Median Income [3]	
$28,550	*$27,843*
Persons Living in Poverty [3]	
12%	*14%*
Persons Age 65 or Older [3]	
12%	*11%*

Sources:
1. U.S. Bureau of Census, 1999 Community Population Estimates
2. U.S. Bureau of Census, 1990 & 1999 Community Population Estimates
3. Community Tracking Study Household Survey, 1998-1999

The ABCBS-Baptist affiliation has remained a powerful force in the market, while financial and operational problems have plagued other plans and hospitals.

ABCBS and Baptist Remain Powerful as Competitors Flail

Little Rock's health care market continues to be dominated by ABCBS and Baptist Health System, and their market positions are bolstered by a close alliance. Since 1994, ABCBS and Baptist have had a 50/50 joint venture in the area's largest health maintenance organization (HMO), Health Advantage HMO, and Baptist provides the majority of services to members enrolled in ABCBS's HMO and PPO products.

The alliance reflects a statewide strategy on the part of ABCBS to contract exclusively with regionally dominant hospitals. Some observers believe that these alliances offer consumers a high-quality network at a competitive price. Others say the alliances inhibit competition and may eventually lead to higher costs for consumers.

In Little Rock, the ABCBS-Baptist affiliation has remained a powerful force in the market, while financial and operational problems have plagued other plans and hospitals.

Plan Competition. ABCBS has more than 40 percent of the HMO market share in Little Rock and close to 60 percent statewide. Much of the plan's strength, however, derives from its preferred provider organization (PPO), which has more than 2.5 times the enrollment of its HMO, or approximately 440,000 enrollees statewide.

ABCBS's closest HMO competitor in Little Rock is United Healthcare, which has a 25 percent share of local HMO enrollees, but its visibility in the market appears to be diminishing. Last year, United combined its Arkansas and Tennessee plans and moved many operations to Tennessee, leading some observers to question whether the plan intends to remain in the Little Rock market.

Also on questionable footing is Little Rock's third-largest HMO, QCA QualChoice Health Plan, with 19 percent local HMO market share. Two years ago, this plan, which is owned by the University of Arkansas Medical Sciences (UAMS), Tenet Healthcare Corp., and other equity partners, was positioning itself to compete more aggressively with the ABCBS-Baptist alliance. Now, however, the plan appears to be financially unstable, and observers say that it may have been insolvent at times because of difficulties in meeting state risk reserve requirements. Whether QualChoice's equity partners will provide additional funding is not known, and observers suggest that a change for the plan—perhaps new ownership or, in a worst-case scenario, dissolution—may be forthcoming.

Meanwhile, in December 2000, CIGNA pulled out of the Arkansas HMO market, affecting approximately 11,000 enrollees (some of whom switched to CIGNA's PPO or indemnity products the plan continues to offer). Although CIGNA was not a major player in Little Rock when it exited the market, its departure was significant in that it decreased the number of health insurance options available to consumers and reduced competition.

In all, approximately 40 insurers have reportedly left the Arkansas market since 1998. Although it is unclear whether all of these insurers offered health insurance coverage, most observers agree that health plan competition has decreased. Besides CIGNA, other notable health plan exits during the past two years include American Investors Life and American Healthcare Providers, Inc., each of which had close to 20,000 PPO or HMO enrollees at peak enrollment. Apart from Blue Cross Blue Shield of Missouri, which entered the market with HMO and PPO products, no new plans have entered the Little Rock market since 1998. Arkansas' small size and relatively rural demographics, along with the poor health and lower socioeconomic status of its population, have made the state a less attractive place for health plans to enter and operate.

Hospital Competition. Competition also has faltered in Little Rock's hospital market, and Baptist has maintained a significant competitive advantage. Although Baptist's market share in Little Rock

proper is similar to that of its nearest competitor, St. Vincent's Health System, Baptist attracts significant additional volume from referrals from 80 affiliated facilities located throughout the state. To counter this competitive advantage, St. Vincent's has invested in NovaSys Health Network, a statewide provider network created in 1996 that includes 6,000 physicians and 90 acute care hospitals. Despite its arrangement with NovaSys, St. Vincent's has not been as successful as Baptist in attracting referrals from outside the market.

Moreover, recent financial and operational problems have eroded the competitive position of St. Vincent's. After providing an infusion of capital, the Denver-based Catholic Health Initiatives, which has owned St. Vincent's since 1997, curtailed additional support because of its own financial losses. Meanwhile, St. Vincent's has experienced declining volume in cardiac surgery following the pullout of a major cardiology group in 1997 that left to form the Arkansas Heart Hospital. Additionally, St. Vincent's 1998 acquisition of another local hospital has reportedly further strained its finances. At the same time, St. Vincent's has experienced staff reductions and multiple changes in executive management over the past two years, and, in June 2000, it became the first private Arkansas hospital with a unionized nursing workforce, following a legal challenge by the National Labor Relations Board.

Expanded Specialty Care Capacity Threatens Hospital Revenue

New service capacity in Little Rock and outlying communities threatens hospitals with reduced patient volume in tertiary care and other lucrative services. Since 1998, open-heart surgery programs have opened in two competing hospitals in Searcy, an area 45 minutes northeast of Little Rock. Open-heart surgery programs now exist in several other Arkansas cities, and some communities are beginning to add neonatal intensive care capacity.

Observers expressed concern that the limited volume associated with these community programs poses potential quality problems. They also fear that this service expansion, coupled with the higher overhead structure of these outlying hospitals, will drive up overall health care costs in the state. Yet another concern is that Little Rock hospitals' loss of tertiary service volume may constrain the hospitals' ability to cross-subsidize important, yet less profitable, services.

The expansion of physician-owned ambulatory surgery centers (ASCs) also poses a threat to revenues of Little Rock hospitals. Six new ASCs have opened since 1998, nearly tripling the number of such facilities in the market. A few of the ASCs are multispecialty centers, but most are limited to a single specialty (e.g., orthopedics, gastroenterology or otolaryngology). Three of the ASCs are joint ownership arrangements between physicians and hospitals, but the others are physician-owned or, in one case, owned by a national firm. In addition, physicians are adding ancillary services in their private offices or through freestanding diagnostic centers. Some say that this build-up of ambulatory care capacity is a response by specialists to maintain income levels by supplementing their revenue with facility fees.

For the past several years, inpatient capacity has continued to increase in Little Rock. The Arkansas Heart Hospital opened in 1997, and there has been a steady increase in the facility's number of staffed beds since then. Additionally, both Baptist and St. Vincent's have opened new inpatient facilities in North Little Rock since 1998. While Baptist's facility was a replacement, St. Vincent's was an addition. Both facilities opened with fewer beds than originally planned, perhaps indicating that the market is reaching its upper limit of inpatient capacity.

Health Insurance Status

Little Rock	*Metropolitan areas above 200,000 population*
Persons under Age 65 with No Health Insurance [1]	
15%	*15%*
Children under Age 18 with No Health Insurance [1]	
12%	*11%*
Employees Working for Private Firms that Offer Coverage [2]	
82%	*84%*
Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance [2]	
$158	*$181*

Sources:
1. Community Tracking Study Household Survey, 1998-1999
2. Robert Wood Johnson Foundation Employer Health Insurance Survey, 1997

Health System Characteristics

Little Rock	*Metropolitan areas above 200,000 population*
Staffed Hospital Beds per 1,000 Population [1]	
5.0	*2.8*
Physicians per 1,000 Population [2]	
3.1	*2.3*
HMO Penetration, 1997 [3]	
25%	*32%*
HMO Penetration, 1999 [4]	
28%	*36%*

Sources:
1. American Hospital Association, 1998
2. Area Resource File, 1998 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)
3. InterStudy Competitive Edge 8.1
4. InterStudy Competitive Edge 10.1

Whatever hopes remained in 1998 that managed care would help to control health care costs in Little Rock have dimmed.

Premiums Rise as Cost Controls Falter

Whatever hopes remained in 1998 that managed care would help to control health care costs in Little Rock have dimmed. For 2001, premium increases of 20 percent or more for commercial products are commonplace. Plans report that the premium increases are necessitated in part by rapid increases in the utilization of both inpatient and ambulatory care services in Little Rock—already among the highest in the country. Since 1998, for example, plans report that 10 to 20 percent increases in the utilization of ambulatory care services are not uncommon, noting that the increases for those in HMOs are larger than for those in PPOs. Observers say that plans considering market entry naively believe they can reduce utilization, when, in fact, no plan has been able to do so. Expanded capacity, the availability of complex procedures like bone marrow transplants, increased consumer demand and weak managed care controls are all said to be contributing to the higher utilization.

Plans' ability to control utilization also has been complicated by a 1998 Arkansas law requiring plans that offered only a fully insured, closed-panel HMO to also offer a point-of-service (POS), PPO or indemnity option to employers. Plans report that this law has steered enrollment away from traditional gatekeeper HMO products toward more loosely managed POS and PPO products.

Contributing further to the market's escalating premiums are pressures placed on plans by physicians to maintain high payment levels. Plans in Little Rock, although sometimes failing to pay promptly, have been generous in their payments to physicians. Within Little Rock's predominantly discounted fee-for-service context, physician payment rates go up to 150 percent or more of the Medicare fee schedule. Some observers believe that high physician payment rates are necessary to help physicians subsidize care because of the relatively low reimbursement received for the state's Medicare beneficiaries.

Mirroring the experience in the commercial sector, managed care's influence on public sector programs in Little Rock has been limited. Arkansas' Medicaid program relies on a primary care case-management model, and state officials say that there are no plans to move to a risk-based model. There has been an attempt to introduce managed care for the Medicare population, but only 4 percent of beneficiaries statewide have enrolled. Observers cite Medicare beneficiaries' preference for Medigap coverage and negative media coverage of HMOs as deterrents to enrollment.

Meanwhile, during the past two years, premiums for Medicare+Choice have risen 124 percent, and this has been without including prescription drug coverage in its benefit package. Following United Healthcare and CIGNA's departure from the Medicare+Choice market in 2000, only ABCBS's Health Advantage HMO participates, leading some to question if the plan will continue to participate.

Employers Shift Costs

While they have expressed disappointment with managed care's inability to control costs, employers have not responded aggressively to rising premiums. Many large employers have reconfigured their health benefits by increasing deductibles and copayments, rather than passing premium increases along to employees through increased contributions. With this strategy, they have essentially shifted a larger share of the increased costs to employees who use health services.

A few small employers have responded to rising premiums by converting their employees from group to individual coverage in what observers describe as a form of defined contribution. Under these arrangements, the employer provides the employee with a fixed contribution to help cover the cost of coverage. The employee

is responsible for all costs beyond the employer's fixed contribution and can choose from among a range of individual coverage options offered through the employer that have varying premiums, deductibles and copayments. Observers believe several possible future developments may prompt more employers to move to some form of defined contribution, including declining affordability of health insurance, passage of state mandates for minimum benefit packages or passage of federal legislation that increases the risk of employer liability.

Safety Net Struggles

Like most hospitals in Little Rock, the market's leading provider of indigent care, UAMS, has been hard hit by substantial cuts in Medicare reimbursement brought about by the Balanced Budget Act of 1997. An accounting error that resulted in a controversial write-off of $113 million in uncollectable patient accounts also created difficulty for the hospital, as did its continued ownership interest in financially troubled QualChoice.

In 2000, some financial relief for UAMS came with a $2 million appropriation from the state's General Improvement Fund for indigent care services, but the one-time cash infusion covers only a fraction of the $20 to $25 million losses the hospital incurred in each of the two previous years. Some express concern about UAMS's continuing financial instability, because—other than the Arkansas Children's Hospital and a few free and church-based clinics that operate with limited hours—UAMS is the predominant safety net provider for adults in Little Rock.

The Arkansas Children's Hospital, a key Little Rock safety net provider for children, has fared better financially than UAMS, in part because of its specialized pediatric services. The Arkansas Children's Hospital has been successful in securing numerous managed care contracts, including one with ABCBS, and is the plan's only HMO in-network hospital in Little Rock other than Baptist. State efforts, such as the State Children's Health Insurance Program (SCHIP), have reduced the number of uninsured children and helped to maintain UAMS's financial health.

Arkansas has relied largely on outside monies such as SCHIP and, more recently, tobacco settlement funds to finance initiatives aimed at reducing the 15 percent of the population who are uninsured. Since Arkansas' SCHIP program, ARKids 1st, began in 1997, the program has enrolled more than 70,000 previously uninsured children. Many believe that, despite the state's continuing high rate of uninsurance, almost all children now have the opportunity to obtain some form of coverage.

Currently, however, the state and federal governments are embroiled in a contentious disagreement over regulations that require all children eligible for Medicaid to be enrolled in that program instead of ARKids 1st. The federal government maintains that Medicaid-eligible children are entitled to the comparatively more expansive Medicaid benefit package than what they would receive through ARKids 1st. The state, on the other hand, argues that its current policy boosts the number of children with some form of coverage, because it does not carry with it the stigma that is often associated with Medicaid. State officials hope that the Bush administration signals new leeway for state preferences and, thus, receptiveness to the state's position within the federal government.

In another initiative aimed at reducing the number of uninsured, Arkansas voters approved a ballot initiative during the November 2000 election directing 30 percent of the state's average annual tobacco settlement of $62 million ($1.62 billion over 25 years) to expand Medicaid eligibility for adults. Under the expansion, approximately 40,000 additional adults could become eligible for Medicaid.

Some express concern about the continuing financial instability of UAMS, the predominant safety net provider for adults in Little Rock.

As costs continue to rise, many have voiced concern that uninsurance rates may begin to increase, placing further strain on an already fragile safety net.

Issues to Track

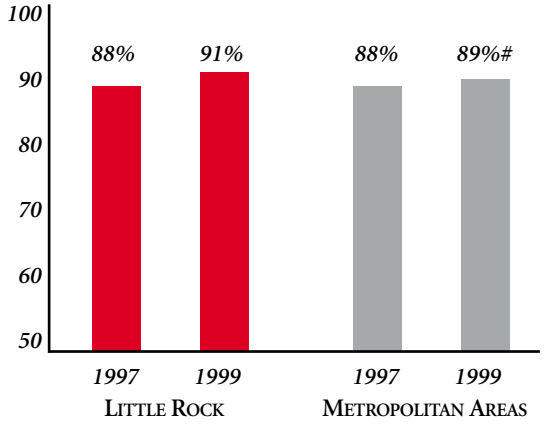
ABCBS and Baptist individually and together, through their alliance, continue to dominate the Little Rock health care market, gaining strength as competition weakens in both the hospital and health plan sectors. Meanwhile, hospitals are faced with a different type of threat as they increasingly confront hospitals in outlying communities and local physicians vying for key lucrative services that were once the exclusive domain of Little Rock hospitals. These expansions appear to encourage increased utilization at a time of slack cost controls in the market. Double-digit premium increases have become pervasive, and employers have begun to respond by shifting more costs to employees, particularly those using health services. As costs continue to rise, many have voiced concern that uninsurance rates may begin to increase, placing further strain on an already fragile safety net.

As the health care system in Little Rock evolves, the following issues will be important to track:

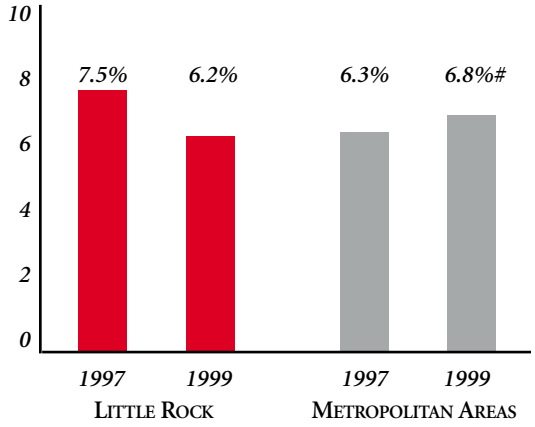
- Will greater competition emerge in Little Rock's health plan and hospital markets? What market-driven or regulatory actions will need to be taken for this to occur?
- How will the development of tertiary care services in outlying communities and the build-up of ambulatory care capacity by Little Rock's physicians affect hospitals' service volume and financial viability? Will any steps be taken to control the market's capacity and service expansions?
- Will defined-contribution approaches gain an additional foothold in the market? In what other ways will employers respond to rising premiums? Will premium increases contribute to a higher rate of uninsurance?
- How will access to care for the uninsured be affected by initiatives like ARKids 1st and Medicaid expansion? What impact will these initiatives have on the safety net?

Little Rock's Experience with the Local Health System, 1997 and 1999

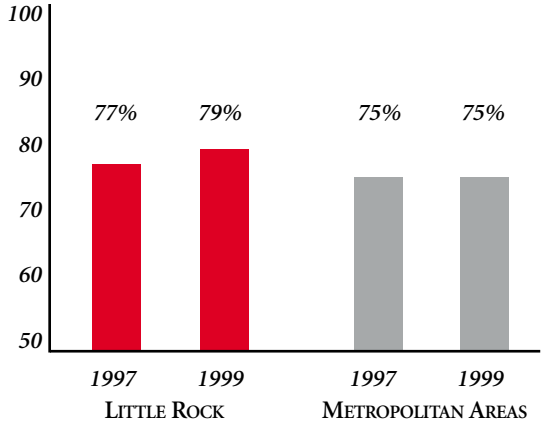
Persons Satisfied with the Health Care They Received in the Last 12 Months



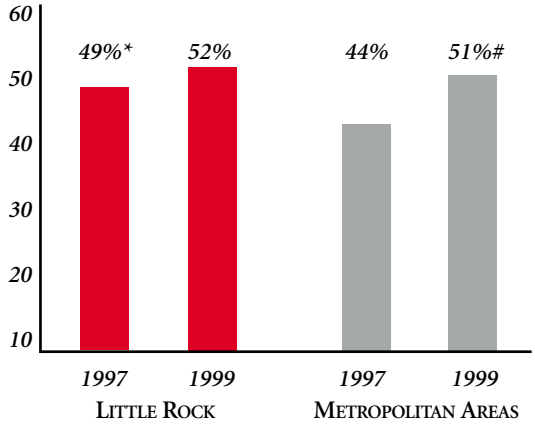
Persons Who Did Not Get Needed Medical Care in the Last 12 Months



Physicians Agreeing that It Is Possible to Provide High-Quality Care to Their Patients



Persons with Insurance that Requires Gatekeeping



** Site value is significantly different from the mean for metropolitan areas over 200,000 population.*
 # Statistically significant difference between 1997 and 1999 at p< .05.

The information in these graphs comes from the Household and Physician Surveys conducted in 1996-1997 and 1998-1999 as part of HSC's Community Tracking Study.

The Community Tracking Study, the major effort of the Center for Studying Health System Change (HSC), tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in 12 communities. The Community Report series documents the findings from the third round of site visits. Analyses based on site visit and survey data from the Community Tracking Study are published by HSC in *Issue Briefs, Data Bulletins* and peer-reviewed journals. These publications are available at www.hschange.org.

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